

GALA GENERAL ANAESTHESIA vs LOCAL ANAESTHESIA FOR CAROTID SURGERY

HOSPITAL DISCHARGE OR 7 DAY POST-SURGERY FOLLOW-UP FORM

To the surgeon and anaesthetist: Please complete questions 1-29 (pages 1, 2 & 3) as soon as you have finished the operation. The other questions should be answered at hospital discharge, or seven days post-surgery or death whichever is soonest. If this patient is no longer going to have surgery please give details of any anaesthetic given and complete questions 1 to 4 (page 1) and 30 to 38 (page 3) together with the contact details (page 4).

HOSPITAL CODE NUMBER: or Hospital name | _____ |

PATIENT DETAILS:

Family name: | _____ |

First names: | _____ | Hospital number | _____ |

Date of birth: ____/____/____ (dd/mm/yyyy)

SURGERY DETAILS:

1. Was this patient admitted for surgery? **YES** *Please tick one box*
NO → If NO please give reason:

2. Date of admission for surgery (dd/mm/yyyy) | ____/____/____ |

3. Has the patient taken any of the following in the 48 hours before surgery? *Please tick appropriate box(s)*

Aspirin	<input type="checkbox"/>	→ Name of drug: _____
Clopidogrel	<input type="checkbox"/>	
Dipyridamole	<input type="checkbox"/>	
Warfarin	<input type="checkbox"/>	
Other antiplatelet	<input type="checkbox"/>	
None of the above taken	<input type="checkbox"/>	

4. Was carotid surgery carried out? **YES** *Please tick one box*
NO

If NO please give the reason below: (then please answer questions 30 – 38 on p 3 and the contact details on p 4)

5. Date of carotid surgery: (dd/mm/yyyy) | ____/____/____ |

6. Side of carotid surgery: **Right** *Please tick one box*
Left

7. Type of surgery: **Conventional** *Please tick one box*
Eversion
Other *If Other please say surgery type | _____ |*

8. Duration of surgery: (skin to skin time) | _____ | minutes

9. Shunt used? **YES** **NO** If shunt was used please give reason below:

10. Patch used? **YES** **NO**
11. Intraoperative heparin used? → Dose: | _____ | units
12. Heparin reversed? → Dose: | _____ | mgs Protamine

13. Weight of patient: | _____ | pounds or | _____ | kgs **Actual weight/ Estimated weight** (delete as appropriate)

GENERAL ANAESTHESIA:

Please Note: **ONLY** answer questions 14 to 18 if this was the principal method of anaesthesia.

		YES	NO
14.	General anaesthesia used?	<input type="checkbox"/>	<input type="checkbox"/>
	<i>(If YES complete questions 15 to 18 below)</i>		
15.	Pre-medication?	<input type="checkbox"/>	<input type="checkbox"/>
16.	Maintenance technique:		
	- total IV anaesthesia?	<input type="checkbox"/>	<input type="checkbox"/>
	- use of volatile agents?	<input type="checkbox"/>	<input type="checkbox"/>
	- use of nitrous oxide?	<input type="checkbox"/>	<input type="checkbox"/>
	- use of muscle relaxants?	<input type="checkbox"/>	<input type="checkbox"/>
17.	Did blood pressure require manipulation up?	<input type="checkbox"/>	<input type="checkbox"/>
18.	Did blood pressure require manipulation down?	<input type="checkbox"/>	<input type="checkbox"/>

LOCAL ANAESTHESIA:

Please Note: **ONLY** answer questions 19 to 28 if this was the principal method of anaesthesia.

		YES	NO
19.	Local anaesthesia used?	<input type="checkbox"/>	<input type="checkbox"/>
	<i>If YES complete questions 20 to 28 below</i>		
20.	Pre-medication?	<input type="checkbox"/>	<input type="checkbox"/>
21.	Local infiltration used for anaesthesia?	<input type="checkbox"/>	<input type="checkbox"/>
22.	Cervical plexus block used?	<input type="checkbox"/>	<input type="checkbox"/>
23.	Additional intra-operative local anaesthetic?	<input type="checkbox"/>	<input type="checkbox"/>
24.	Did blood pressure require manipulation up?	<input type="checkbox"/>	<input type="checkbox"/>
25.	Did blood pressure require manipulation down?	<input type="checkbox"/>	<input type="checkbox"/>
26.	Intra-operative sedative?	<input type="checkbox"/>	<input type="checkbox"/>
27.	Intra-operative analgesia?	<input type="checkbox"/>	<input type="checkbox"/>
28.	Conversion to general anaesthesia?	<input type="checkbox"/>	<input type="checkbox"/>

FOR ALL PATIENTS:

29.	Was the type of anaesthesia used the same as allocated at trial entry?	YES	NO
		<input type="checkbox"/>	<input type="checkbox"/>

If **NO** please give the reasons in the space below:

NAME OF SURGEON CARRYING OUT THE OPERATION | _____ |

PLEASE INDICATE THE OPERATING SURGEON'S GRADE (tick one box)

Trainee	<input type="checkbox"/>	
Consultant	<input type="checkbox"/>	(Consultant = an individual who has completed their training and is capable of doing the procedure with no supervision, and who has an appropriate specialist qualification.)
Other	<input type="checkbox"/>	If you tick OTHER please say what grade below: _____

NAME OF MOST SENIOR SURGEON PRESENT AT THE OPERATING TABLE | _____ |

PLEASE INDICATE THE GRADE OF THE MOST SENIOR SURGEON PRESENT AT THE OPERATING TABLE (tick one box)

Trainee	<input type="checkbox"/>	
Consultant	<input type="checkbox"/>	(Consultant = an individual who has completed their training and is capable of doing the procedure with no supervision, and who has an appropriate specialist qualification.)
Other	<input type="checkbox"/>	If you tick OTHER please say what grade below: _____

NAME OF ANAESTHETIST ADMINISTERING ANAESTHESIA | _____ |

PLEASE INDICATE THE ADMINISTERING ANESTHETIST'S GRADE (tick one box)

- Trainee
- Consultant (Consultant = an individual who has completed their training and is capable of doing the procedure with no supervision, and who has an appropriate specialist qualification.)
- Other Please state what grade | _____ |

NAME OF MOST SENIOR ANAESTHETIST PRESENT IN THE OPERATING THEATRE | _____ |

PLEASE INDICATE THE GRADE OF THE MOST SENIOR ANAESTHETIST PRESENT IN THE OPERATING THEATRE (tick one box)

- Trainee
- Consultant (Consultant = an individual who has completed their training and is capable of doing the procedure with no supervision, and who has an appropriate specialist qualification.)
- Other Please state what grade | _____ |

Please complete the rest of this form at hospital discharge, or 7 days post-surgery or death, whichever occurs first.

COMPLICATIONS:

Since randomisation has the patient had any of the following? (Please tick all that apply)

	YES	NO	
30. Stroke of any type (> 24 hours)? *	<input type="checkbox"/>	<input type="checkbox"/>	_____ /_____ /_____ (dd/mm/yyyy)
31. Transient ischaemic attack (brain) (< 24 hours)? *	<input type="checkbox"/>	<input type="checkbox"/>	_____ /_____ /_____ (dd/mm/yyyy)
32. Retinal infarction (> 24 hours)? *	<input type="checkbox"/>	<input type="checkbox"/>	_____ /_____ /_____ (dd/mm/yyyy)
33. Amaurosis fugax (< 24 hours)? *	<input type="checkbox"/>	<input type="checkbox"/>	_____ /_____ /_____ (dd/mm/yyyy)
34. Myocardial infarction? *	<input type="checkbox"/>	<input type="checkbox"/>	_____ /_____ /_____ (dd/mm/yyyy)
35. New or worsening angina?	<input type="checkbox"/>	<input type="checkbox"/>	_____ /_____ /_____ (dd/mm/yyyy)
36. New arrhythmia requiring treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____ /_____ /_____ (dd/mm/yyyy)
37. New or worsening heart failure?	<input type="checkbox"/>	<input type="checkbox"/>	_____ /_____ /_____ (dd/mm/yyyy)
38. Has this patient died? *	<input type="checkbox"/>	<input type="checkbox"/>	_____ /_____ /_____ (dd/mm/yyyy)

For any YES answers please give the date below:

If this patient has died please give cause of death below:

Cause of death:

* If you have answered Yes to any question above with an asterisk (*) please complete a MAJOR EVENT FORM and send it to the GALA Trial Office

Between the induction of anaesthesia and today's date did the patient have any of the following?

	YES	NO
39. Deep vein thrombosis?	<input type="checkbox"/>	<input type="checkbox"/>
40. Pulmonary embolism?	<input type="checkbox"/>	<input type="checkbox"/>
41. Retention of urine?	<input type="checkbox"/>	<input type="checkbox"/>
42. Chest infection?	<input type="checkbox"/>	<input type="checkbox"/>
43. Wound haematoma?	<input type="checkbox"/>	<input type="checkbox"/>
44. Wound infection?	<input type="checkbox"/>	<input type="checkbox"/>
45. Any other medical or surgical complication?	<input type="checkbox"/>	<input type="checkbox"/>

Q45 - If YES please describe below ↴

46. Did this patient require re-operation? YES
NO

If YES please give the reason ↴

Please turn over/

PLACE AND DURATION OF HOSPITAL STAY:

47. Number of hours spent in recovery room after surgery hours
48. Number of hours spent in Intensive Therapy Unit after surgery (Level 3) hours Level 3 - Intensive Care. Nurse patient ratio 1:1, with dedicated senior and trainee medical staff.
49. Number of hours spent in High Dependency Unit after surgery (Level 2, Level 1) hours Level 2 - High Dependency with organ support, but not mechanical ventilation. Nurse patient ratio 1:2, with dedicated senior and trainee medical staff.
Level 1 - HDU. Close monitoring. Nurse patient ratio 1:4. No dedicated medical staff.
50. Has this patient been discharged from hospital? **YES**
NO
51. If YES give Date of discharge (dd/mm/yyyy) | ____/____/____ |

OR

If still in hospital, give Ward number or name: Ward | _____ |

If still in hospital, give the name of the doctor responsible for their care Dr | _____ |

CONTACT DETAILS: PATIENT'S FULL POSTAL ADDRESS

(Please print clearly or attach a sticky label)

Post code	
Telephone	

PATIENT'S FAMILY DOCTOR DETAILS

Family Doctor's name	
Family Doctor's full postal address	
Post code	
Telephone	

NAME OF COLLABORATOR COMPLETING THIS FORM | _____ |

TODAY'S DATE | ____/____/____ | dd/mm/yyyy

Please post or fax this form to:
 GALA Trial Co-ordinator, Neurosciences Trials Unit, Bramwell Dott Building,
 Western General Hospital, Crewe Road, Edinburgh EH4 2XU.
 Fax: + 44 131 332 5150
 (an envelope is provided)